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TO: **Arkansas Medicaid Health Care Provider – Nurse Practitioner**

DATE: **March 1, 2005**

SUBJECT: **PROPOSED - Provider Manual Update Transmittal No. 46**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	3-1-05
214.210	10-13-03	214.210	3-1-05
214.800 – 214.910	10-13-03	214.800 – 214.812	3-1-05
		214.950 – 214.952	3-1-05
252.470 – 252.492	10-13-03	252.470 – 252.482	3-1-05

Explanation of Updates

Section 201.000 has been revised to add a statement informing providers that persons and entities that are excluded or debarred under state or federal law, regulation, or rule, are not eligible to enroll, or remain enrolled, as Medicaid providers.

Section 214.210 has been revised to delete incorrect information regarding the availability of extension of benefits for nurse practitioner services. Nurse Practitioner services are limited to 12 visits per state fiscal year. For services furnished to recipients age 21 and older, extensions of the established benefit are not available. The established benefit limit does not apply to recipients under age 21.

Section 214.800 has been revised to clarify and provide information about the Occupational, Physical and Speech Therapy Program. Therapy services must be provided by qualified occupational, physical and speech therapists. Therapy services are not payable to nurse practitioners.

Sections 214.810 through 214.812 have been added to the manual to include the guidelines for occupational, physical and speech therapy retrospective reviews. This is for informational purposes only.

Sections 214.950 through 214.952 have been added to inform providers of the beneficiary's right to appeal denial of extension of benefits. The process for requesting an appeal has been explained.

Section 252.470, which included information not applicable to the nurse practitioner program, has been deleted. Sections following that information have been renumbered as Sections 252.470 through 252.482. Minor revisions have been made for clarification purposes.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

201.000 Arkansas Medicaid Participation Requirements for Nurse Practitioners 3-1-05

The Arkansas Medicaid Program enrolls advanced or registered nurse practitioners for participation in the Nurse Practitioner Program. Providers of nurse practitioner services must meet the following requirements to be eligible for participation in the Arkansas Medicaid Program:

A. The provider of nurse practitioner services must meet the enrollment criteria for his or her specialty as outlined in Sections 201.300 through 201.340.

B. The nurse practitioner must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (form W-9). **View or print a provider application (Form DMS-652), Medicaid contract (Form DMS-653) and Request for Taxpayer Identification Number and Certification (Form W-9).**

C. The following documents must be submitted with the provider application and Medicaid contract:

1. A copy of all certifications and licenses verifying compliance with enrollment criteria for the specialty to be practiced. (See Sections 201.300 through 201.340 of this manual.)
2. Providers of nurse practitioner services have the option of enrolling in the Title XVIII (Medicare) Program. If enrolled in Title XVIII, the provider must notify the Medicaid Provider Enrollment Unit of their Medicare number. Out-of-state providers must submit a copy of their Title XVIII (Medicare) certification.
3. Nurse practitioners who have prescriptive authority must furnish documentation of their prescriptive authority certification. Any changes in prescriptive authority must be immediately reported to Arkansas Medicaid.
4. Certifications and licenses received subsequent to enrollment must be submitted to the Arkansas Medicaid Program within 30 days of issue.

D. The Arkansas Medicaid Program must approve the provider application and Medicaid contract as a condition of participation in the Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule, are not eligible to enroll, or to remain enrolled, as Medicaid providers.

214.210 General Nurse Practitioner Services Benefit Limits 3-1-05

For beneficiaries aged 21 and older, services provided in a nurse practitioner's office, a patient's home or nursing home are limited to 12 visits per state fiscal year (July 1 through June 30).

A. Extensions of the established benefit limit are not available.

B. The established benefit limit does not apply to individuals under age 21.

214.800 Occupational, Physical and Speech Therapy 3-1-05

A. Medicaid covers occupational, physical, and speech therapy services for beneficiaries under age 21. Therapy services must be provided by a qualified therapist. Therapy services are not covered as nurse practitioner services. The following is provided for the nurse practitioner's information. All physical therapy services require a referral and a prescription from the patient's primary care physician (PCP) or attending physician.

B. A referral for therapy services must be renewed every six months.

A written prescription is required from the PCP or attending physician for evaluation services and for treatment services. The prescribing physician must sign the prescription with his or her original signature. The prescription for treatment is valid for one year unless the prescribing physician specifies a shorter period.

C. An initial evaluation must be prescribed separately from treatment services. The initial evaluation must be reviewed by the physician and a customized treatment plan prescribed.

D. Form DMS-640, Occupational, Physical and Speech Therapy for Medicaid Eligible Recipients Under Age 21 Prescription/Referral, must be used to obtain the referral for services and the written prescription for an evaluation or for treatment for recipients under age 21.

The PCP or attending physician must complete and sign the DMS-640 with his or her original signature when making a referral or prescribing a therapy service. A rubber stamp or automated signature is not acceptable. A copy of the prescription must be maintained in the recipient's records. The original prescription is to be maintained by the physician. **View or print form DMS-640**.

E. Evaluations for physical therapy are limited to four 30-minute units per state fiscal year.

Individual and group physical therapy services are *limited to a maximum of four 15-minute units of therapy per day.* Group therapy must be provided in a group size of no more than 4 clients per group.

214.810 Occupational, Physical and Speech Therapy Guidelines for Retrospective Review 3-1-05

Though nurse practitioners are not reimbursed for occupational, physical and speech therapy services, it is important for the nurse practitioner to be aware of Medicaid's guidelines to document medical necessity.

214.811 Occupational and Physical Therapy Guidelines 3-1-05

Occupational, physical and speech therapists must adhere to the specific guidelines for retrospective review.

A. Therapy services for individuals must be medically necessary to the treatment of the individual's medical condition as prescribed by the individual's PCP. Nurse practitioners are not reimbursed for occupational or physical therapy services.

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.

2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical therapist.

3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition (See medical necessity definition in the Glossary of this manual).

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for physical therapy includes a comprehensive evaluation of the patient's physical deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Frequency, Intensity and Duration of Physical Therapy Services:

Frequency, intensity and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.

2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical therapy services. These services can be provided to the child as part of a home program that can be implemented by the child's caregivers and do not necessarily require the skilled services of a physical therapist to perform safely and effectively.

3. Duration of Services: Therapy services should be provided as long as reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring or establishment of a home program should be implemented.

C. Progress Notes:

1. Child's name.

2. Date of service.

3. Time in and time out of each therapy session.

4. Objectives addressed (should coincide with the plan of care).

5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form measurement.

6. Progress notes must be legible.

7. Therapists must sign each date of entry with a full signature and credentials.

8. Graduate students must have the supervising physical therapist co-sign progress notes.

214.812 Speech-Language Therapy Retrospective Review Guidelines 3-1-05

A. Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.

2. The services must be of such a level of complexity, or the patient's condition must be such, that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.

3. There must be reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See medical necessity in glossary of the Arkansas Medicaid manual.)

A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. Assessment for speech-language therapy includes a comprehensive evaluation of the patient's speech language deficits and functional limitations, treatment planned and goals to address each identified problem.

B. Evaluations:

In order to determine that speech-language therapy services are medically necessary, an evaluation must contain the following information:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history and gestational age.
5. Standardized test results, including all subtest scores, if applicable. Test results, if applicable, should be adjusted for prematurity if the child is one year old or less and this should be noted in the evaluation.
6. An assessment of the results of the evaluation including recommendations for frequency and intensity of treatment.
7. The child should be tested in their native language; if not, an explanation must be provided in the evaluation.
8. Signature and credentials of the therapist performing the evaluation.

The mental measurement yearbook is the standard reference to determine good reliability/validity of the test(s) administered in the evaluation.

C. Birth to Three:

1. — (minus) 1.5 SD (standard score of 77) below the mean in two areas (expressive, receptive) or a — (minus) 2.0 SD (standard score of 70) below the mean in one area to qualify for language therapy.
2. Two language tests must be reported with at least one of these being a global norm-referenced standardized test with good reliability/validity. The second test may be criterion referenced.

214.950 Beneficiary Due Process 3-1-05

214.951 Appealing an Adverse Decision 3-1-05

When the Division of Medical Services (DMS) denies a benefit extension request for laboratory and x-ray services, and the beneficiary wishes to appeal the denial, the beneficiary may request a fair hearing.

An appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Human Services within 30 days of the date on the letter from DMS explaining the denial. Appeal requests must be submitted to the Department of Human Services Appeals and Hearings Section. View or print the Department of Human Services Appeals and Hearings Section contact information.

214.952 Requesting Initiation or Continuation of Services Pending the Outcome of an Appeal 3-1-05

A. A beneficiary may request that services be continued (or that services begin, in cases where coverage has been denied), pending the outcome of an appeal.

1. Appeals that include a request to begin or continue services must be received by the DHS Appeals and Hearing Section within 10 days of the date on the DMS denial letter.
2. When such requests are made and timely received by the Appeals and Hearings Section, DMS will authorize the services and notify the provider and beneficiary.
3. The provider will be reimbursed for services furnished under these circumstances and for which the provider correctly bills Medicaid.

B. If the beneficiary loses the appeal, DMS will take action to recover from the beneficiary Medicaid's payments for the services that were provided pending the outcome of the appeal.

252.470 Prior Authorization Control Number 3-1-05

When billing for procedures that have been prior authorized, the 10-digit prior authorization control number must be entered in the CMS-1500 claim format. See Section 220.000 of this manual for additional information on prior authorization.

252.480 Medicare 10-13-03

252.481 Services Prior to Medicare Entitlement 3-1-05

Services that have been denied by Medicare with the explanation "Services Prior to Medicare Entitlement" may be filed with Medicaid. These services should be filed on the CMS-1500 claim form for processing and forwarded to the EDS Inquiry Unit. **View or print the EDS Inquiry Unit contact information**.

These services usually can be filed electronically unless they are covered by Medicare and the beneficiary was 65 or older on the date of service. It may be necessary to attach a copy of the Medicare denial to the claim.

A note of explanation should accompany these claims in order that they may receive special handling.

252.482 Services Not Medicare Approved 3-1-05

Services that are not Medicare approved for patients with joint Medicare/Medicaid coverage usually are not payable by Medicaid unless they are services that are not covered by Medicare, but are covered by Medicaid. There are exceptions and those may require special handling.